

Mail Claims to: Blue Cross Dental Customer Service
P. O. Box 9201 Oxnard, CA 93031-9201

Dental Claim Form

This form is not intended for electronic claim submissions.

Blue Cross and Blue Shield of Georgia

Please refer to your ID card for the correct mailing address and Customer Service phone number.

EMPLOTE	EPARIA														
1. PATIE	NT NAME			TIONSHIP TO I		3. MAL	SEX LE FEMALE			-	RTHDATE 5. IF Y YEAR	FULL TIME SCHOOL	STUE	DENT CITY	
6. EMPLOYEE NAME FIRST MIDDLE LAST							7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NUMBER 8. EMPLOYEE/SUBSCRIBER BIRTHDATE MONTH DAY YEAR								
EMP	EMPLOYEE MAILING ADDRESS 9. EMPLOYER (COMPANY) NAME AND ADDRESS														
CITY,	CITY, STATE, ZIP														
													÷.		
ANO	ANOTHER DENTAL PLAN?														
12. EMPLOYEE/SUBSCRIBER NAME EMPLOYEE/SUBSCRIBER (UNDER OTHER CARRIER) SOCIAL SECURITY NO.									BIRTHDATE RELATIONSHIP TO PATIENT MO./DAY/YR						
auth	 13. I have been informed of the treatment plan and associated fees. I authorize the release of any information needed to determine benefits for the duration of this claim. 14. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. 														
> CICNED (Detiont/Cuerdian) DATE									DATE						
SIGNED (Patient/Guardian) DATE SIGNED (Employee/Subscriber) DATE															
DENTIST PART B															
15. NAME OF BILLING DENTIST OR DENTAL ENTITY							 Is treatment of occupational or injury? 	illness	NO	YES	If yes, e	nter brief descripti	on and o	dates	
16. MAILING ADDRESS							4. Is treatment fauto accident the accident?	t or							
								Are any services vered by another ntal plan?							
17. DENTIST SSN OR T.I.N. 18. DENTIST LIC # 19. PHONE # 26.							6. If prosthesi his initial place				(If no, reason for replaceme	nt)		27. Date of prior placement	
20. First visit date of current series: 21. Place of treatment Office Hosp ECF Other				22. Radiographs enclosed? Yes, How many? No			28. Is treatment for orthodontics?				If service already commenced: Date appliances placed? Months treatment remaining?				
29. EXAN	INATION AND	TREATMEN	IT PLAN								<u></u>				
				PRE-TREAT	TMENT ESTIMA	ATE O	R STATEMEN	T OF AC	TUAL	SERVIC	CE				
TOOTH # or LETTER	OOTH SURFACE DESCRIPTION OF SERVICE # or						DATE SERVICE PERFORMED			PROCEDURE #	FEE FOR ADMINISTRATI		ADMINISTRATIVE		
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IDENTIEV	ALL MISSING	TEETH WIT	1 AN "Y"					1			TOTAL FEE	1	_		
DENTIFY ALL MISSING TEETH WITH AN "X" PERMANENT REMARKS FOR UNUSUAL SERV								VICES O	RDIAG	NOSIS					
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17											ALLOWED AMOUNT PATIENT PAID	/	\dashv		
PRIMARY															
A B C D E F G H I J T S R Q P O N M L K											AMOUNT PATIENT PAID BALANCE DUE	-	\dashv		
	30. I hereby certify that the procedures as indicated by date have been completed or are in progress and that the fees submitted are the fees I usually charge and accept for such													for such	
procedures	3.														
DENTIST	SIGNATURE						DATE								